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## **Systemic Barriers That Prevent Mental Health Services From Being Accessed by the Deaf Population**

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Systemic Barriers That Prevent Mental Health Services  
From Being Accessed by the Deaf Population

Jen Ruther-Uhrich

Submitted in partial fulfillment of  
the requirements for the degree of  
Master of Social Work

AUGSBURG COLLEGE  
MINNEAPOLIS, MINNESOTA

2003

“Success is to be measured not so much by the position that one has reached in life as by the obstacles which one has overcome.”

-Booker T. Washington

MASTER OF SOCIAL WORK  
AUGSBURG COLLEGE  
MINNEAPOLIS, MINNESOTA

CERTIFICATE OF APPROVAL

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This Masters Thesis is dedicated from my heart and soul to my son Haäkin. You're entire life experience to date has been with a busy mommy in college. I will never forget my thesis presentation because every time I looked at your adorable little face, I saw your smile beaming with encouragement and buoyancy. You also brought your math test (that you did superbly on) and gave an extraordinary presentation to my thesis committee and guests. You are the inspiration for my resiliency and determination. I have every confidence that your life achievements, triumphs and successes will surpass my own.

I love you!

Love,

Mom

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## ABSTRACT

# SYSTEMIC BARRIERS THAT PREVENT MENTAL HEALTH SERVICES FROM BEING ACCESSED BY THE DEAF POPULATION

JEN RUTHER-UHRICH

JUNE 9, 2003

Mental health services are essential and need to be equally accessible and non-discriminatory to all individuals within our society. Traditionally, the Deaf community has encountered many hindrances when attempting to access mental health services. This study examines the systemic barriers that prevent Deaf individuals from obtaining mental health services in the Twin Cities Metro and regional area. Questionnaires were sent out to 100 individuals that serve Deaf adults with mental illness within the Twin Cities Metro Area. The results from the 48 service providers' questionnaires responses show specific qualitative barriers; Community Service Agencies, Cultural Competency, Deaf Individuals with Additional Needs, Stigma, Discrimination and Stereotypes. The researcher follows with a discussion of the findings' implications on the impact of program development, state legislation, community service councils, and policies that would provide viable linkages to the accessibility for Deaf individuals.

## Chapter I

### Introduction

A Deaf female, Jane Doe, living in the community calls her social worker through the relay service. The social worker receives the call from Jane Doe. Jane informs the social worker through the relay operator that she wants to kill herself and she has a mechanism to do so, a bottle of pills and a bottle of Vodka. She has been drinking the Vodka all night and it is now 8 AM. She tells the social worker that she is about to take the bottle of pills and end her life. She then hangs up.

The social worker calls 911 and the county crisis team, and reports a severe level of lethality. The social worker, emergency personnel and the crisis team plan to go to Jane Doe's apartment. The social worker knows a minimal amount of sign language. An interpreter needs to be called. The county crisis team does not know the policy in securing a sign language interpreter. After a 45-minute conversation with the county, the social worker finds that the county will not fund an emergency interpreting service, although federal legislation (ADA 1990) mandates state, community and local access to communication.

Jane Doe's 13-year-old son, Johnny is at the apartment when the police and ambulance show up. Johnny ends up interpreting for his mother in crisis. Johnny is crying and the mother has taken the pills. The social worker is not there yet, but the crisis team is there. The crisis team uses Johnny to gain insight into what Jane Doe has ingested. Johnny knows his mother has been drinking, but has no idea how many or what kind of pills she has taken. Jane is

brought to the emergency room at the local hospital. As the ambulance is driving away, the social worker shows up and calls child protective services to place Johnny in temporary foster care.

Once at the hospital, the nurse calls for an interpreter, and is told that it will be at least 2 hours before an interpreter can get there. The medical team is not able to communicate with Jane to find out what she has ingested. Jane becomes unconscious and the medical team begins to pump her stomach. She is placed in the Intensive Care Unit for 48 hours. After being moved to a sub-acute care bed, the psychiatrist meets with Jane Doe for a pre-discharge assessment. There is no interpreter for the assessment and the psychiatrist deems her mentally stable and able to return home. It is also important to mention that there is no bed available on the mental health unit at this time. At the time of discharge, there is no interpreter and Jane is not aware that she is being discharged. The discharge nurse calls the social worker and explains that Jane has been discharged to her home. The social worker is working on a placement with another client and cannot leave the site. The social worker calls her supervisor and the supervisor goes to Jane Doe's apartment. Jane is on the floor and her face is blue. The supervisor calls 911 and begins CPR. The Emergency Medical Technicians show up at the home and attempt to revive Jane Doe. Jane Doe cannot be revived and she is pronounced dead.

Although this story is anecdotal, it reflects the researcher's field of experience in mental health services provided for the Deaf community. Moreover, the researcher's experience has initiated the research topic and draws

on a personal qualitative experience and professional work history. This research will show the definitive barriers, which clearly exist, in reasonable fair access to mental health services. This research also purports to add insight and serve as a vehicle of system change in diminishing these institutionalized discriminatory hindrances.

## Chapter II

### Review of the Literature

#### Overview

Professionals that work in the field of providing mental health services must strive to increase their knowledge of other cultures and ethnic backgrounds from that of their own. This literature review will provide an overview of information regarding barriers to services provided for the Deaf and Hard of Hearing population. The literature review will then identify the gaps in the literature and identify the research question.

#### Description of the Deaf and Hard of Hearing Population

The Deaf and Hard of Hearing populations lie on a continuum. At one end of the continuum, there are individuals with some degree of hearing loss who will assimilate and identify themselves as hearing. At the other end of the continuum there are individuals who identify themselves as culturally Deaf. These individuals refute the medical/audiological perspective on hearing loss and have a specific culture that they identify with. There is heterogeneity that exists in all dimensions of this continuum. Thus, when working with individuals, it is important that the professional know how the client identifies themselves within the Deaf and Hard of Hearing population. The professional must have working knowledge of the different cultural aspects of the Deaf and Hard of Hearing population. The professional must also do a thorough investigation into the client's history. When working with an individual, one must keep in mind that due to the heterogeneity of the population, each person will have their own

preference and style of communication. It is important not to stereotype individuals within the Deaf and Hard of Hearing population.

To describe the Deaf and Hard of Hearing population, Roberts and Hindley (1999) state that there are four commonly used terms. The first term is "hearing impaired", which stems from the medical and audiological view of hearing loss. This term is the most widely known in hearing culture and is used mostly by professionals who are not familiar with the cultural aspects of deafness. The term "hearing impaired" implies that there is an impairment and something needs to be fixed.

Along the continuum between the hearing and Deaf world, there lies the group of people who are considered "deaf" with a lower-case d. Padden (1980) states that the word "deaf" refers to a medical condition of not being able to hear well. The term "deaf" is used to describe people who identify themselves as having a hearing loss to the extent that they are classified as profoundly deaf, but they are not a part of the specific Deaf culture. Harvey (1989, p. 67) suggests that these individuals use oral methods for communication, rather than a form of sign language.

Going back to the continuum, there are people who identify themselves as "Hard of Hearing". The majority of individuals who identify as Hard of Hearing will have a lesser degree of hearing loss than a person who identifies as deaf. People who are Hard of Hearing are more likely to use certain Assisted Listening Devices (ALDs) to assist with the understanding of speech. The individual who is hard-of-hearing is more likely to use a spoken language, possibly in conjunction



with some form of sign language. A person who identifies as such, might also use speechreading techniques to understand what people are saying. Harvey (1989, p.67) describes that people who are Hard of Hearing tend to feel stuck living in between two different worlds, the Deaf world and the hearing world. Hard of Hearing individuals commonly feel that they are not fully accepted in either realm. It is also reported that they do not feel they fit in with the lower-case d group either. For example, one Hard of Hearing individual states "I may be hearing impaired like them [deaf persons], but I'm not *that* deaf" (Harvey, 1989, p. 67). However, depending on individual characteristics and background, it may be possible for someone to flow along the continuum between the different cultures.

Finally, there is the term "Deaf", with an upper-case d. This term describes a distinct part of the population that identify themselves as members of Deaf culture. Deaf people in this respect, have their own culture and language. The majority of people who are Deaf depend on a visual-spatial language for effective and accurate communication. The sign system most widely used in America is American Sign Language (ASL), and it cannot be directly "translated" into English. It has its own grammatical rules that are separate from those of the English language. Therefore, people who are Deaf have communication needs that are different from those of hearing people (Harvey, 1989, p. 68).

People who are Deaf tend to feel isolated from the hearing population. This isolation is often due to the communication and cultural barriers between the Deaf and hearing communities. Isolation or alienation can occur in the

individual's everyday interaction within the hearing world, or it can occur within the family unit. Ninety percent of all parents of deaf children are hearing (Guthmann, 1998). The majority of these parents had never met a d/Deaf or hard-of-hearing person before their own child. They do not know how to effectively communicate with a Deaf person and are unaware of Deaf culture. It is most likely that the child is the only deaf or hard-of-hearing person within the whole family. The child can feel isolated in a hearing world with which they cannot communicate ([Http://www.rit.edu/~257www/paper.html](http://www.rit.edu/~257www/paper.html)).

#### Barriers to Accessing Services

Hearing service providers need to be aware of the cultural differences and challenges that exist between the hearing and Deaf communities. For the hearing worker who is not familiar with sign language or Deaf culture, these challenges will be greatly exaggerated. Elliott, Glass and Evans (1987) suggest that "a hearing therapist who has never been to a deaf club, never attended a residential school for the deaf, never experienced the speed of the deaf community grapevine, may miss nuances of meaning in the responses of a deaf client. The hearing therapist can only assume what it is like to grow up without hearing" (p. 135).

Main barriers that have been identified throughout past research have been lack of adequate communication and lack of cultural competency of the service provider.

## Challenges in accessing Chemical Dependency/Substance Abuse

### Treatment

Communication, or lack thereof, can be a barrier in many parts of the system that Deaf individuals will encounter. First of all, communication within the majority hearing culture is transferred back and forth by speaking and focusing on English reading and writing. Sometimes certain pertinent information does not reach the Deaf population in a timely manner. For example, over fifteen years ago, a nationwide attempt was launched into the public schools to educate and prevent substance abuse, which are still in place today. These education and prevention programs focus on the risks of using chemicals and describe various avenues for help if there is an addiction. These programs are inappropriate for the Deaf community, one reason being that the materials are inaccessible. Because English is their second language, the majority of Deaf students read and write English at a lesser scored proficiency than their hearing peers (Guthmann, Swan and Gendreau, 1994). A good portion of the written material that is used to teach children about drug and alcohol addiction is written for the native English speaker. The majority of the videotapes that have been utilized by the programs are not captioned. This same phenomenon occurs within the mainstream hearing society. There are public service announcements run on television that warn of the dangers of alcohol and drug use, but most of them are not captioned. Because of this inaccessibility, knowledge and information about chemical dependency rarely reach the Deaf community.

The communication barriers continue when a Deaf individual seeks

treatment for substance abuse. The main complication with placement of individuals who are chemically dependent and Deaf into mainstream treatment is communication. Materials used within treatment centers designed for hearing people heavily emphasize tasks that focus on reading and writing skills (Guthmann & Sandberg, 1997). These activities are not effective with Deaf individuals in treatment. The Substance and Alcohol Intervention Services for the Deaf (2000) recommends a multimedia approach. Education should be through "overhead transparencies, posters, charts, slides and closed captioned video tapes." This will lessen the communication barrier and will allow for the Deaf individual to fully understand the educational aspects of treatment.

Assessment of a Deaf individual's drug and alcohol use can be even more difficult due to language and communication barriers. Guthmann and Sandberg (1997) state that the first problem is use of terminology by the assessor. Since chemical dependency language is not used within Deaf culture, most of the terms are new and unfamiliar. Many times, if the individual does not understand a term, they will not ask for clarification. This may hinder the validity of the assessment because the client may be answering "yes" to a question that is a significant diagnostic feature of chemical dependency, rather than answering a true "no" (Guthmann & Sandberg, 1995). Two clear examples would be the use of the terms "blackout" and "DUI", or "DWI" (Sandberg, 1991). The term "blackout" refers to a period of time in which an individual is awake and functioning but after which, has no recollection of some or all of the events during that period. The term DUI refers to Driving Under the Influence and DWI is

Driving While Intoxicated. When using these terms, the interviewer may have to explain these situations in greater detail for the client. During the chemical assessment of a patient who is Deaf, it is extremely important that communication is clear and the interviewer is aware of cultural differences. To facilitate communication and make a bridge between Deaf and hearing culture, a sign language interpreter is used.

Interpreters. During a chemical dependency assessment, the addition of an interpreter can be a concern for three reasons. First, the interpreter may not be fully qualified to interpret in this specialized setting. What this means is that the interpreter may not have the vocabulary and knowledge that is specific to chemical dependency (Guthmann, 1998). Or, the relevant information could be missing from either the interpreter's English or ASL vocabulary. Thus, the meaning of specific diagnostic questions may not be correctly communicated to the deaf client. This would change the reliability and validity of the chemical dependency assessment. There are very few interpreter-training programs that are designed to teach the necessary and relevant information and vocabulary that is necessary during a chemical dependency assessment.

A second concern regarding the addition of the interpreter involves a dynamic change in the interview session. With the addition of a third party, the meeting automatically becomes less private and the issue of confidentiality arises. A final concern when considering an interpreter for chemical dependency assessment is interpreter availability. The interpreters who are qualified to interpret in this specialized field are limited. When assessing Deaf individuals for

substance abuse, it is up to the assessor to make sure that the interpreter is qualified for interpreting in this situation. Guthmann and Sandberg (1997) state that a qualified interpreter means someone who is certified by the Registry of Interpreters for the Deaf or the National Association for the Deaf and who is familiar with vocabulary and concepts related to substance abuse. It is imperative that these qualities are taken into consideration to ensure effective and reliable communication.

Communication barriers also hamper connections to other peers in the recovery program. Even if there is an interpreter present, interactions with the other hearing clients will be changed because of the addition of a third party. Paul Anderson from the Hazelden Center for Youth and Families (Kizilos, 1995, p. 3) says that "if a person doesn't hook up with a peer group in a meaningful way, their treatment is going to be significantly hampered. Recovery is difficult if you continue to be alienated, because addiction thrives on isolation and alienation."

#### Challenges in Gaining Access to Mental Health Services

The first study that focused on the understanding of deafness and mental illness took place in Norway and was published in 1929 by psychiatrist Viggo C. Hansen (Vernon & Daigle-King, 1999). Hansen observed 36 people who were deaf and patients in some Norwegian psychiatric hospitals. At the time of the study, thirty-one percent of the deaf patients that were studied were without an official diagnosis. Regardless of having a diagnosis of mental illness, the deaf patients were found as having longer hospitalization stays.

The second study to be published related to deafness and mental illness was created in New York, between 1963 and 1966 by two psychiatrists named Ken Altshuler and Jon Rainer. They worked under the supervision of a genetic psychiatrist by the name of Franz Kallmann (Vernon & Daigle-King, 1999). These psychiatrists studied the entire population (230 persons) of psychiatric inpatients within the New York State hospitals. The statistical representation of deaf inpatients diagnosed with schizophrenia was 1.6% of the total deaf population in New York State. This was compared to the statistical representation of hearing inpatients that had a diagnosis of schizophrenia, which was 0.43% of New York State's hospital population (Vernon & Daigle-King, 1999). According to Vernon and Daigle-King (1999), the "three researchers felt that the higher overall rate of schizophrenia among the Deaf occurred because schizophrenia was often used as a wastebasket category for deaf patients, whose poor communication and English communication skills made their diagnosis difficult" (p. 52).

In 1969 at the Psychosomatic and Psychiatric Institute of Michael Reese Hospital, Roy R. Grinker, Sr. (psychiatrist and neurologist) and his team studied 159 deaf patients over the time frame of three years (Vernon & Daigle-King, 1999). The team studied patients relative to their diagnoses and found that "the frustration and isolation faced by the deaf patients played a major role in their mental health problems but was not a primary cause of schizophrenia in those suffering from the disorder" (p. 57).

A Norwegian psychiatrist, Terje Basilier, studied 94 deaf individuals in

Norwegian psychiatric hospitals (Vernon & Daigle-King, 1999). All of these patients were former students in Norwegian schools for the Deaf between the years of 1916 and 1966. Basilier found that there was a higher statistical representation of mental illness within the deaf population as opposed to mental illness within the hearing population. He stated "If the staff does not know sign language, then therapy is bitterly slow, if present at all" (Vernon & Daigle-King, 1999, p. 58).

One piece of literature discusses using a systemic approach to treating mental health problems within Deaf individuals. This literature came from a report of the National Conference on Mental Health Services for Deaf People, sponsored by the New York State Psychiatric Institute. This conference was held in Houston, Texas, February 14-17, 1968. In one chapter Brown (1969) states:

It was this emphasis on modifying behaviors through the alteration of environmental expectations, requirements, and consequences that constitutes what we will call a contemporary psycho-educational approach to mental health and deafness. Our major thesis is that if we wish to understand, prevent, or eliminate what are often termed "mental health" problems in deaf individuals, we must view the causes and solutions as residing, not within the individual or in the nature of this handicap, but as stemming, generally, from environmental interactions. (p. 26)

From the same conference, there was literature that outlined the contributions of social work practice to the field of mental health and deafness (Hurwitz, 1969).

Hurwitz (1969) states:



Social work is one of the helping professions. Its avowed aim is to "assist individuals and groups to identify and resolve or minimize problems arising out of disequilibrium between themselves and their environment". The technical aspects of this concept will be enlarged upon later; it may suffice to note here that social work is largely concerned with balance between man and his environment, not looking at man alone but at man-in-his-situation and in-his-relations to other people. The critical dimensions of social work are the individual and society. (p. 69)

Another article focuses on expressing the need for the cultural aspects of Deafness to be considered when doing psychological diagnostic assessments (Lala, Jr., 1998). Lala Jr. states the following:

As long as the communication needs of deaf people are not perceived and met, psychological treatment must necessarily be less than maximally effective. Because of poor communication, many deaf people in the past were misdiagnosed as mentally retarded or otherwise judged, however subtly, as "inferior". Public attitudes toward deaf people are even now not consistently enlightened. (p. 315).

#### Other Cultures Experiencing Barriers to Accessing Mental Health Services

Barriers occurring in the system that make it difficult for Deaf and Hard of Hearing people to access mental health services also make it difficult for other cultures and minority groups attempting to access the same services. One study, with regards to the Southeast Asian population, states, "available mental health services for this population are often inadequate, inappropriate and

inaccessible" (Ying, p. 69, 2001). The study suggests that social service agencies that provide services to this population usually provide services that help the client with concrete needs instead of psychological needs. Another added barrier is that "there is a culturally based stigma against mental health disturbance" (Ying, p. 69, 2001).

Another study by Al-Krenawi and Graham (2000) illuminate culturally sensitive social work practice with Arab clients in mental health settings. The study "emphasizes that principles of mental health practice have common and transnational applications" (Al-Krenawi & Graham, p. 10, 2000). The study indicates "non-Western societies, find psychiatric and psychological intervention and family and marital therapies stigmatizing" (Al-Krenawi & Graham, p. 12, 2000).

The issue of language barriers when working with refugees was mentioned in a study that focused on a ten-year period and the mental health service delivery system. Boehnlein (1987) stated, "Interpreters with mental health training are essential in facilitating communication between refugee patients and care providers. Interpreters are not always available in mainstream medical or mental health clinics." (p. 766).

Morrow (1993) discusses how barriers occurring on all systemic levels for gay and lesbian adolescents trying to access services. The adolescent themselves may be confused and experience dissonance about their sexual orientation. Barriers can also occur when a gay or lesbian adolescent attempts to get services from a social worker that has a heterosexist bias. There are also

barriers that occur within the family system as well, such as fear and pejorative myths.

#### Gaps in the Literature

As previously described, there is a wide array of deafness and the culture of deafness. Though there has been improvement in the past 10 years of services that are accessible to the deaf and hard of hearing population, there are still gaps in knowledge needing to be addressed.

After reviewing the literature, the researcher could not find any specific study related to strengths inherent within the Deaf community that allows for community involvement with the part of the population that have additional challenges. Also vacant from literature is research about the family system of the Deaf adult individual with mental illness. This is not the only system that is missing from being researched that the Deaf individual with mental illness interacts with. Other systems missed include employment, housing, medical, and educational (collegiate). Lastly, missing from prominent literature is the effectiveness of certain treatments with this specialized population.

## Chapter III

### Conceptual Framework

#### Overview

There are certain barriers that lie within contextual systems that can make it difficult for a Deaf or hard of hearing person to get their needs met from their environment. Professionals that work with Deaf individuals know that there are certain barriers that these individuals face when trying to access mental health services. While exploring answers to the research question, this study will attempt to categorize and base the barriers within a theoretical schema. Systems theory and the ecological systems theoretical approach will be used to view the person and environment in a holistic approach. Also, when observing any population of different cultural background, a multicultural perspective should be used.

#### Systems Theory

Contrary to viewing individuals as having only relationships with their environment that are cause and effect, systems theory uses a more holistic approach. Compton and Galaway (1999) state that systems theory allows for “problems to be identified in the transactions, lack of fit, opportunities, and limitations among individuals and the various levels of environment that make up our social systems” (pg. 29). By using systems theory, the professional is viewing the individual and its environment as a complex whole that is greater than the sum of its parts (Turner, 1996).

There are four parts in the structure of the ecological environment (Bronfenbrenner, 1979). Micro-systems is the categorical level in which the individual directly interacts with the immediate situations and environment. Face-to-face interactions occur between and among individuals in a micro-system. This level includes the individual's experiences within their own family, school, work, or in other settings (Turner, 1996). Ashford, LeCroy and Lortie (1997) state that an individual will be part of many different micro-systems at the same time. Thus, a change in one micro-system will have a ripple effect. The individual will be affected in that micro-system as well as others.

The second level within the systemic structure is referred to as the meso-system. The meso-system consists of the micro-systems that the individual has direct contact with. The key to the meso-system is the interconnectedness of these micro-systems. This category consists of personal systems such as "major groups, organizations, and institutions that touch the daily life of the individual such as school, work, church, recreations and community resources" (Turner, 1996, p. 608).

The exo-system is comprised of the larger social institutions and systems in which the individual does not directly interact with (Ashford et al., 1997). Thus, the individual is affected by the exo-system, but not directly. Ashford et al. (1997), give an example of the exo-system as being parents' work settings. The child is not directly involved with the parents' work, but it does affect the child in many ways.

Lastly, there is the macro-system in which the micro-system, meso-system and exo-system are located. The macro-system represents the broad cultural and sub-cultural contexts. Bronfenbrenner (1979) state that the macro-system is the overarching “patterns of ideology and organization of the social institutions common to a particular culture or subculture” (p. 8). Turner, (1996) states that the macro-system includes structures such as technology, housing, language, laws and customs (p. 608).

It is important for the mental health professional to identify the relevant systems that the individual is a part of. For example, Turner (1996) states that the “social work practitioner must strive for a full understanding of the complex interactions between the client and all levels of the social and physical systems as well as the meaning that the client assigns to each of these interactions” (p. 605). This will aid the social worker in determining the appropriate point of intervention. Interventions can take place in any of the four systems or it could mean modifying problem interactions between the individual and the environment.

#### Reciprocal Causality

One-way to describe how a system functions is reciprocal causality, or circularity. Interaction within the system and between other systems is thought of as circular and sequential, not linear. Thus, person A acts and person B reacts. This will cause person A to react to person B’s initial reaction, and so on. This interaction could also occur between two systems. Many times, within the family system, this interaction is a continuous cycle and viewed as a problem. Thus the

starting and ending point of the interactions becomes unimportant. The practitioner must intervene to break this cycle.

Individual impacts reality. Each time an individual acts, they are impacting reality. They can have an effect on reality in either a positive or negative manner, which can produce either positive or negative results. However, there is a dialectic involved with this idea. When the individual acts, there needs to be a reciprocal action from the environment as well.

Reality impacts individual. Every individual's idea of reality is different. The way we view our own reality is through our own perspective. Just as the individual affects reality, reality in turn will impact the person. This pattern creates circularity. If a mental health professional focuses only on how the individual is being impacted by reality, this becomes linear and creates a victim mentality. With the individual being viewed as a victim, there is no chance for empowerment. There will also be no chance for the person to take responsibility for behavior and decisions that they make. It is important that the mental health professional understand this dialectic.

### Ecological Systems Theory

Ecological systems theory is based on two different biological theories. The first is the science of ecology, and the second is systems theory. The ecological systems theory attempts to explain how people interact with their social and physical environments. During their life, a person will try to adapt and change through reciprocal interactions with their environments. People constantly are trying to achieve a good level of fit with their environments. Stress

is the result when this does not happen.

Turner (1996) describes two types of environments that people interact with and attempt to adapt to, social and physical. Social environments include bureaucratic organizations and social networks. Some systems within the environment can be oppressive and isolative. Some can even reinforce deviant and dysfunctional behaviors. Physical environments refer to things such as the person's habitat, niche and the natural world that they live in.

### Multicultural Approach

Dungee-Anderson and Beckett (1995) focus on a communication process model for use with multicultural interventions. Communication can be non-verbal or verbal. To be able to provide therapeutic communication for the individual, the practitioner must be self-aware and have some knowledge of the multicultural facets that are related to the client. Along with the verbal communication, the service provider's non-verbal communication can either be congruent or non-congruent. Congruency aids the service provider in multicultural intervention with the client. A big barrier may be communication between the service provider and the individual receiving the services. It is imperative that the service provider approaches each individual from a multicultural perspective.

Dungee-Anderson and Beckett (1995) illustrate three of eight steps that social work practitioners can take to practice appropriate multicultural interventions. The first step is to "acknowledge cultural differences" (p. 463). By acknowledging cultural differences, the practitioner is sensitized to the individual differences among clients and also differences between groups. The second



step is to “know self” (p. 463). Practitioners need to be aware of their own cultural identity because “customs, values and beliefs are internalized” and affect multicultural practice (p. 465). The third functional step is to “know other cultures”. Dungee-Anderson and Beckett (1995) state:

Multiculturally competent practitioners are not necessarily experts in many different cultures. Rather they are aware of cultural values and patterns that motivate their own and their clients’ behaviors. They are sensitive to differences and do not project their own internalized cultural responses onto practice situations. The multiculturally competent practitioner feels comfortable asking clients about customs or values with which he or she is not familiar. (p. 465).

McGoldrick, Giordano and Pearce (1996) discuss therapy issues when working with families of a different ethnic or cultural background:

Helping a person achieve a stronger sense of self may require resolving cultural conflicts within the family, between it and the community, or in the wider context in which the family is embedded. A part of this process involves identifying and consciously selecting ethnic values we wish to retain and carry on. (p. 20).

Also made apparent is another reason to use the multicultural approach is to reduce the incidence of misdiagnoses of mental illness. There are variances of the concept of mental illness between individuals and groups. People differ in the following: their experience of pain, what they label as a symptom, communication about their pain or symptoms, beliefs about its cause, attitudes

towards helpers (doctors and therapists), and the treatment they desire or expect (McGoldrick, Giordano & Pearce, 1996, p. 9). Solomon (1992) states, "labels of psychopathology are social indicators of the stress experienced by populations that lack power; thus, we should expect the oppressed and underprivileged to show more psychopathology." (p. 4).

Multiculturalism needs to encompass approaches to the gay, lesbian, bisexual and transgender communities as well. Morrow (1993) suggests "social workers must become aware of their own homophobia and how it affects their work with clients of any sexual orientation. It is important to avoid a heterosexist bias of assuming that all clients are heterosexual." (p. 658).

Payne (1997) encourages a policy of "multi-culturalism by affirming the reality of cultural diversity, allowing individuals to keep much that is distinctive about their cultural traditions and integrating diverse cultural traditions in society, thus opposing a single, dominant culture. Such knowledge makes services more appropriate and responsive." (p. 249).

### Theoretical Application

When there is an imbalance between the individual and their environment, the individual may seek the help of a professional. This research bases its premise on Systems Theory, Ecological Systems Theory and the Multicultural approach. By using these theories and approaches as the basis for this study, the researcher can classify the barriers and a schema of the systemic structure, and the obstacles that lie within, can be created. By identifying the barriers, this study adds to the current meager body of literature regarding obstacles for Deaf

individuals attempting to access mental health services. This research will also promote program planning and implementation based on principal social work theory.

## Chapter IV

### Methodology

#### Overview

Research methods in social work practice are fundamentally based in qualitative investigation. Qualitative research methods in social work practice attempt to gain insight into the multiple realities of individuals, families and groups, and “to understand the full complexity of the individual’s experience” (Bailey, 1992, p. 30). In this particular research the investigator aims to understand the dynamic experience of systematic service delivery toward a specific population. This research does not generalize to broader populations, but rather offers a glimpse into the workings of the population under study. This study will give rise to emerging systemic barriers through the process of data analysis gained from questionnaire response through the research question.

#### Research Question

This study focuses on probing one main research question. The research question asks, “What are the systemic barriers that prevent Deaf individuals from obtaining mental health services?”

This study is designed to gather the participants’ ideas regarding barriers that occur within a human service delivery system. The study will utilize inductive reasoning to categorize these barriers so that certain common key points within the Deaf and Hard of Hearing service system will illuminate the strengths, needs and gaps within the services available.

### Operational Definition

The operational definition of a “barrier” is a concept that each participant creates based on their subjective understanding of their own life experiences and therefore will be defined through written narrative on the questionnaire.

Furthermore, in reviewing the description of the Deaf and Hard of Hearing populations in the literature review, an operational definition of the population is also understood. The operational definition of “system” are those organizations that deal with providing services for the Deaf and Hard of Hearing population.

### Research Design

In an effort to gain understanding of the systemic barriers that prevent mental health services from being accessed by the Deaf population, a qualitative and quantitative design and survey method is a pragmatic research structure. Hepworth, Rooney and Larsen (1997) state “By combining qualitative research methods with survey research methods, we can benefit from the strengths of survey research while we offset its weaknesses regarding superficiality, missing social context, inflexibility, artificiality, and questionable validity.” (p. 382). A self-administered mail questionnaire was used to generate and identify themes regarding systemic barriers that Deaf individuals must face when trying to access mental health services. The survey uses a battery of closed-response questions (n = 16) (Thyer, 2001, p. 154), which allows participants to respond to concerns that the investigator has outlined in this study. In addition, the questions offer an opportunity for the participants to respond through personal narrative which reflects their experience as a service provider.

## The Sample

Potential participants were identified through two possibilities. First of all, the participant or the organization that they work for may have been listed in the Professional and Consumer Resource Guide for People Who are Deaf and Hard of Hearing that was compiled by the Minnesota Department of Human Services, Deaf and Hard of Hearing Services Division, Metro Region (Minnesota Department of Human Services, Metro Regional Service Center for Deaf and Hard of Hearing People [MNDHS MRSC for DHHP], 1998, see Appendix E). Participants also may have been sampled by using a kind of purposeful sampling known as snowball or chain techniques (Patton, 1990). Participants were located within different agencies, which are not limited to the following:

elementary/secondary schools, hospitals and clinics and family service agencies/social service agencies, and religious organizations. The sampling design was consisted of a qualitative and quantitative self-administered mail survey that was distributed to providers including: doctors, physician's assistants, nurses, social workers, psychologists, psychiatrists, interpreters, chemical dependency counselors, rehabilitation specialists, advocates and pastors. A total of 100 questionnaires were distributed to potential participants in February 2003. Of the 100 surveys sent out, 48 were returned, yielding a response rate of 48%.

### Characteristics of the study population.

This study attempted to include a diverse population regarding age, race, ethnicity, culture, gender, disability, degree of hearing loss and sexual orientation. The characteristics of this population could not be guaranteed

representative from all of the groups due to the time limitations imposed on this study. Eligibility to participate in this study was based on certain design parameters. This study focused on collecting data from within the parameters of a diverse population; however, several sub-specific groups will be more representative (i.e. persons with disabilities, persons with hearing loss, and individuals working for local county and state agencies and non-profit agencies). Approximately 65% of the 48 respondents were hearing, 29% were Deaf and 6% Hard of Hearing.

#### Data Collection

The questionnaire consisted of 16 questions divided into two sections (see Appendix B). Section A questions agencies and organizations currently serving Deaf adults in mental health services within the Twin Cities Metro area. Section A also attempts to ascertain general information about the population of deaf individuals from the respective organizations where participants are employed. Section A contains seven questions. Section B is designed to gain information about the context and the environment that a Deaf individual lives within. Section B contains nine questions. There is additional room for commentary at the end of the questionnaire. The survey questionnaire provides the phone number of the researcher to assist any of the participants in completing the questionnaire. Lastly, the questionnaire contains a section for participant contact information for the researcher to send back a summary of the data to interested participants. Rubin and Babbie (2001) list certain steps to be taken when creating a culturally sensitive instrument. They suggest to “use knowledgeable informants in the

study population (perhaps even hiring a consultant from that population) to assess potential problems in the cultural sensitivity of the existing measures or to help to develop new measures.” (p. 235). The researcher had the questionnaire pre-tested by Jeff Belevender, a self-identified Deaf individual that has strong ties with his own Deaf culture and language (J. Belevender, personal communication, November 15, 2002). Mr. Belevender is a service provider working for a local non-profit agency. He provides mental health services to the population of Deaf adults suffering from mental illness. The pre-tested survey was completed by Mr. Belevender in an approximate 30-minute time frame.

#### Internal and External Validity.

By using a questionnaire approach to measurement and analysis, there are threats to reliability and validity. Internal validity is compromised of the interview variability and interactive effects between interviewers and informants. Some potential threats to internal validity are the frustration of Deaf and Hard of Hearing service professionals that experience a variety of barriers when trying to provide accessible services. The level of frustrations may bias the responses to the questions on the questionnaire to some degree. Nonetheless, the researcher has attempted to collect data from a sample that insures that the “subjects under study were identified and described accurately” (Thyer, 2001, p. 280). External validity is dependent on differences and similarities within the sample. Some potential threats to external validity are: hearing professionals vs. Deaf professionals, variances in funding where the participants are employed and regional variances where service is provided. Generalization to the broader



hearing culture is not feasible due to the nature of the Deaf and Hard of Hearing service sample specific for this kind of interviewing (Thyer, 2001).

### Procedures

Before possible participants were identified, an approval was obtained for use of the Professional and Consumer Resource Guide for Deaf and Hard of Hearing People that was compiled by the Minnesota Department of Human Services, Deaf and Hard of Hearing Services Division (see Appendix E). After possible participants were identified and a list was formulated, the researcher typed and printed the address mailing labels. Each envelope had one information and consent letter and one questionnaire inside (see Appendices A and B). The information and consent letter informed possible participants how and why they were selected. It also informed the possible participants that if they choose to participate, it would take approximately 15 to 20 minutes to complete the questionnaire. Participants were also instructed to leave blank any questions that they would feel uncomfortable in answering. Information regarding confidentiality and the voluntary nature of the study was also included. Risks, benefits and debriefing were also explained (see Appendix A). Possible participants were advised to ask any questions that they had before signing the consent form and filling out the questionnaire. If potential participants agreed to take part in the study, they signed the consent statement at the end of the information and consent letter. A questionnaire was mailed out along with the information and consent letter to be self-administered. Responses to the questionnaire have been studied in an attempt to answer the research question.

Out of 100 mailed questionnaires, the researcher will need at least a 50% response rate to be “considered adequate for analysis and reporting” (Rubin & Babbie, 2001, p. 368). The investigator recruited participants through the distribution of an Information and Consent Letter (see Appendix A) that explained the study. The goal of this study was to receive between 10 and 15% of the total questionnaires mailed. In survey research it is a common protocol to mail out the same questionnaire through the sample in a consecutive period of time. The researcher mailed out 100 questionnaires in mid February with the intent of sending a second mailing along with a postcard encouraging them to fill out the survey. The researcher however was able to gain a 48% return rate on the first mailing. Due to the high return rate, the researcher determined that the sample was adequate enough to proceed with data analysis. One potential variable that may have contributed to the high return rate may have been the vivid concern of professionals wanting to further research regarding the need of mental health services for the Deaf population.

### Data Analysis

The first in qualitative analysis is description. The descriptive questions in this research are: What are the primary and systemic barriers for Deaf individuals seeking mental health services? What are the congruent features of these barriers across service provision? What are the results of the descriptive barriers? What are the gaps and strengths in services? “When data collection has formally ended and it is time to begin the final analysis, the investigator has two primary sources to draw from in organizing the analysis: (1) the questions

that were generated during the conceptual phase of the study and clarified prior to final analysis and (2) analytic insights and interpretations that emerge during data collection” (Patton, 1990, p. 378).

The initial aspect of data analysis was the task of consolidating the raw data into a practical document where the content could be analyzed efficiently. “Content analysis is the process of identifying, coding and categorizing the primary patterns in the data” (Patton, 1990, p. 381). Organizing the data in categorical terms serve to illuminate certain concepts which are discussed in the findings.

## Chapter V

### Findings

The respondents who completed the questionnaire consisted of para-professional and professional service providers. Of the 48 respondents the largest group of service providers represented were social workers, which accounted for 29% of the respondents, 12 social workers. The next largest group of respondents, six respondents, identified themselves as sign language interpreters (15%). Seven respondents (15%) stated that they were in an administrative or managerial position (i.e. Director of Operations, Regional Manager, Vice President, Program Director). Five people (10%) indicated that they worked in health care (i.e. doctors, physicians assistants and nurse practitioners). Of the 48 respondents, 2 identified themselves as psychologists (4%). The remaining 27% of respondents identified themselves as one of the following; Case Manager, Case Coordinator, Housing Support Specialist/Supervisor, Administrative Assistant, Psycho-Social Rehabilitation Specialist, Advocate, Rehabilitation Specialist, Community Service Program Specialist and Deaf and Hard of Hearing teacher. Respondents also identified themselves as one of the following; Deaf (n = 14), Hard of Hearing (n = 4), hearing (n = 31).

This study was designed to gather the participants' ideas regarding barriers to gaining access to mental health services. This study focused on the research question of "What are the systemic barriers that prevent Deaf individuals from obtaining mental health services?" Overall, the findings showed

that there are indeed barriers within the system that prevent mental health services from being accessed by the Deaf population, and the barriers are a telling indicator of the systemic change necessary for effective service delivery. The product of this research serves as a resource for necessary systematic change in social work practice.

Obstructions occur when Deaf individuals attempt to gain access to mental health services provided by the community and broader government service agencies and providers that have limited knowledge or misinformation, fettering the process of effective service delivery to the Deaf community. Nonetheless, social work investigation traditionally relies on a strengths perspective. Thus, there are inherent qualities within Deaf service agencies and organizations that make mental health services accessible despite the challenges.

#### Community Service Agencies

When attempting to access mental health services, Deaf individuals may encounter several obstacles. The findings showed overall that some of the barriers that prevent services from being accessed by the Deaf population are systemic and stem from the community service agencies and providers themselves. The findings also showed that cultural competency is of key importance for these agencies and providers. Also indicative within the findings was the importance of clear effective communication between the individual attempting to receive services and the service provider and agency.

### Cultural competency.

The overwhelming response of community service providers (43 respondents or 90%) reported the lack of cultural competency as a main barrier to Deaf individuals gaining access to mental health services. One respondent stated that, "Professionals need to know about Deaf culture, language, etc. So they can provide better services for Deaf and Hard of Hearing." In illuminating the barriers and needs that are present, one respondent stated:

A mental health professional needs to possess a basic knowledge of the deaf culture, especially language and norms/behaviors. Without this knowledge, a practitioner using the common clinical counseling models may not recognize that possibly a client lacks emotional vocabulary or does not possess adequate communication skills. The inability to adequately describe feelings does not necessarily mean they cannot be exposed using other methods of communicating.

Another respondent stated the following:

Deaf individuals with mental health issues have different cultural and daily coping issues than hearing individuals with mental health issues. Also, deaf individual's responses will be different based on those issues.

Mental health professionals need to recognize the potential of these issues in their lives and distinguish between what is normal and what is not. The deaf individual's explanation of things will be different and often leads to misdiagnosis.

To further the findings that indicate a compelling need for culturally specific training of service providers working with the Deaf community, one participant indicated that “Issues arise regularly re: the isolation within families, work and community due to being cut off from the hearing world due to deafness. An understanding of the impact of deafness is needed in order to adequately treat this issue”. Another participant believed that service providers must know about the “differences between Deaf and Hard of Hearing, backgrounds of how each generalized Deaf/HH may be brought up in childhood”. Also noted by one participant is that “mental health professionals need to understand deafness as a culture and the history of Deaf community oppression”.

Cultural competency and issues regarding communication appear to become more complex when the individual in need of mental health services is Deaf and of another racial or ethnic background other than Caucasian. A large proportion of respondents (35 respondents or 73%) indicated that individuals who are Deaf and of a racial or ethnic group other than Caucasian, do face extra challenges when trying to access mental health services. Nearly one-third of respondents (35%) reported that being of another racial or ethnic background other than Caucasian, and being Deaf created dual cultural and stigmatic barriers. For example, one participant stated, “There have always been challenges for minorities. Especially if a person has several minorities such as a Black Deaf woman.” Another respondent reported “We have several deaf/Hmong clients and to superimpose the challenges and barriers of working with non-English speaking people along with being hearing impaired is a major

challenge.” One participant stated “Multicultural groups face double barriers and stigmas.”

According to the findings, barriers do not always occur because of the service seeker’s minority status. For example, one respondent stated “There is little cultural/racial/ethnic diversity in the professionals serving Deaf and Hard of Hearing individuals. In addition, there are issues related to family support and trauma experiences that make accessing services more difficult.”

#### Deaf vs. hearing service providers.

Regarding cultural competency and accessibility of services, participants were asked their opinion on whether it is more effective for a Deaf individual to receive mental health services from a Deaf professional rather than a hearing professional who knows sign language. Of the 48 respondents, 20 (42%) stated that it is *not* more effective for a Deaf individual to get services from a Deaf professional. One respondent reported, “Hearing people who are thoroughly highly trained in Deaf culture can adequately treat. Just as non-cancer victims can adequately treat someone going through the fear of a recent diagnoses, with enough knowledge of the cancer and empathy”. Another participant stated, “I think being from a particular group gives you more information. I do not believe you necessarily are more effective if you are deaf, or Hmong, or Gay or any other sub group. Your skills and abilities are most important”.

The findings of these 20 respondents (46%) also noted importance of communication as being part of the hearing professional’s effective service delivery. For instance, one respondent stated that the effectiveness “depends on



the professional's background. Ideally they would be proficient in ASL in which case their personal ability to hear or not is unimportant". Another participant highlighted on the importance of communication between the service provider and Deaf individual, adding that the participant believed that "Communication is the key. Two way communication is automatically more effective than three way conversations [via interpreter]".

One barrier that has been noted by 7 respondents (15%) is the inherent size or smallness of the Deaf community. For example, one participant states that for a Deaf individual to see a Deaf service provider "the language can be facilitated better but also concern of past knowledge of the professional, their link in the deaf community and confidentiality is always an issue." Another respondent supported this comment with the notion that "The Deaf professional is more likely to understand background issues, but there are still issues of a small community and mistrust. Deaf may not trust other Deaf." One respondent identified that "the "Deaf small world" is a problem for a Deaf/Deaf pair", but then went on to say, "Deaf professionals would probably understand the language and the issues better than hearing professionals."

Fourteen of the respondents (29%) indicated that they believe it is more effective for a Deaf individual to receive services from a Deaf professional. For instance, one participant noted "Role modeling and understanding is key to developing rapport with the client. There are good hearing professionals but all things equal, a Deaf professional would be more effective". Another respondent indicated, "Cultural competence is of paramount importance. Rapport is

enhanced if the therapist is also Deaf". Lastly, one participant wrote that "Only a Deaf person could truly understand the struggles of another Deaf person".

It is important to note that 14 of the respondents (29%) did not answer this question. Also of surprising importance, the findings were not dependent or significantly related to the respondents' identification of being Deaf, Hard of Hearing or hearing.

#### Providers of involuntary services.

There are times when mental health or other human services are needed and the individual does not seek the services, but instead finds they are in a situation where they are involuntarily receiving services. Out of 48 respondents, 36 respondents (75%) indicated that law enforcement agencies are not adequately equipped and trained to work with a person who is Deaf and in need of crisis intervention. Approximately one-third of respondents (16 or 35%) remarked that communication and lack of cultural knowledge as being barriers. For example, one respondent indicated, "They [law enforcement] lack communication accessibility and cultural understanding". Another added, "Law enforcement needs culture and language training to ensure sensitivity. Hands in motion are misinterpreted and cuffed often!" Also pointing towards a communication barrier is one respondent's comment "I had a patient who was in jail for a week on a charge that most people would have been in for 1-2 days." One participant recounts a personal experience of having "observed the police department making assumptions such as not listening to Deaf staff trying to assist a client in crisis, or not understanding that there is a mental health issue

involved. They [police] see “Deaf” not “Mentally Ill.” One participant described some training that is in place for law enforcement agencies:

Not all law enforcement agencies are equipped and trained; however the Deaf and Hard of Hearing Services Metro Office regularly trains new police recruits for the St. Paul Police Department on an annual basis. The Deaf and Hard of Hearing Services Office has also provided extensive training to the Hennepin County Sheriff Department. They have also provided other training to other police departments.

Interpreters. When a service provider is not proficient in American Sign Language, they must rely on an interpreter (or several interpreters) to communicate with an individual who is Deaf. Of the 48 respondents, 29 (60%) reported that there are not enough sign language interpreters who are adequately trained to interpret in the area of mental health services. The majority of respondents (60%) noted the shortage of sign language interpreters in general such as one respondent’s comment “there is a general shortage of trained and certified interpreters in most service areas.” One respondent stated “In the Metro area we’re fortunate to have several therapists who are fluent in Sign Language. Still interpreters are needed for those who don’t sign. Even though the Metro has several qualified interpreters working in the mental health field, more are needed.”

One participant referred to problems getting interpreters for Chemical Dependency services. “Due to budget cuts, there are not enough interpreters to serve the small groups who have mental health service needs, such as

Alcoholics Anonymous groups.” Another respondent indicates that there are an “insufficient number of support groups available for deaf due to lack of funding for interpreters.”

Approximately one-third (33% or 15) of respondents commented on interpreters not being “adequately trained” for the field of mental health interpreting. For example, one participant reported, “I have experienced interpreters who are uneducated about mental health diagnoses and medication. This can make it difficult for a deaf consumer to properly learn about their disorder.” Another participant indicated, “Not all interpreters are familiar of vocabulary and medicine related to mental health.”

#### Deaf Individuals with Additional Needs

Some individuals who are Deaf may have added challenges when attempting to access mental health services based on their additional needs. These needs go beyond the needs of accessing culturally competent services. For instance, one respondent stated, “Many of my clients have behavioral issues that are communication attempts. Their professionals need to understand this portion of the deaf population.” Another participant reported that ““low” functioning deaf” do not have opportunities to take an active part in planning their mental health care and treatment.

Chemical dependency. Chemical dependency is viewed by 50% (24) of the respondents as being an additional barrier to receiving mental health services. Some respondents noted that the challenges occur with the individual that is in need of services. For example, one participant stated, “The denial and

guilt that is combined with chemical dependency issues is a barrier to seeking mental health assistance.” Another respondent mentioned, “In most cases, the mental illness is treated until stabilization is realized. Then Chemical Dependency treatment follows. Medication management and abstinence is essential to successful transition. Clients often self medicate which complicates the psychiatric interventions.”

Other respondents commented on the organizational and systemic structure of the chemical dependency programs and treatments available. One issue is lack of accessibility. One respondent indicated, “Many deaf individuals have limited access to chemical dependency treatment such as AA and other support groups”. Out of 48 respondents, 8 respondents (17%) stated that accessing interpreters was more difficult due to “lack of funding” and it being “hard to find adequate interpreters.”

Findings also show that respondents were incongruent with their comments when talking about which diagnoses to treat first, the chemical dependency diagnosis, or mental health diagnosis. As one respondent indicated, “The argument persists as to what to treat first, the chemical problem or mental health problem. Deaf Minnesotans are fortunate to have Fairview here and available as well as to get state funding for services and treatment.” The respondent was referring to Fairview Hospital’s Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals (MCDPDHHI).

### Stigma, Discrimination and Stereotypes

An overwhelming 88% (42) of respondents indicated that there is a stigma attached to mental illness within the Deaf community. A common theme throughout the commentaries is that "There is a stigma attached to mental illness in the general community, and this stigma is certainly elevated among the Deaf community." One respondent reported:

Deaf people do not want the hearing world to think there is something wrong mentally with them i.e. mental retardation so, there is a tendency for "normal" deaf people to distance themselves from others who have various types of additional handicaps including mental illness. This tendency is changing somewhat with more "mainstreamed" deaf adults. Another respondent's comment supports the previous one by adding "They are already "different" and experience isolation. Any more ostracism would be unwelcome."

## Chapter VI

### Discussion

The main purpose of this study was to investigate the systemic barriers that a Deaf individual encounters when attempting to gain access to mental health services. Overall, the findings of this research show: There are qualified barriers that prevent mental health services from being accessible to the Deaf population. These barriers are evident in different parts of the Deaf individual's entire systemic human service structure that he/she engages with; Minnesota state or government agencies, non-profits, consumer advocacy organizations and the professional and para-professionals who serve them.

Many of the barriers reported that occur within the individual's system, have to deal with the *Community Service Agencies* themselves. First of all, this study suggests that there is a lack of *Cultural Competency* amongst the majority of service providers. Secondly, this research indicates there are barriers that occur when clients attempt to access mental health services provided by both *Deaf and Hearing Providers*. Thirdly, this study suggests that barriers occur when Deaf individuals are involved with an *Involuntary Service* (i.e., law enforcement). The study also indicates that individuals with additional needs and challenges encounter more barriers that lie beyond just cultural incompetence. Lastly, there seems to be an overlying *Stigma* that Deaf individuals must face relating to Deafness itself and also the stigma attached with mental illness.

When thinking in terms of systems theory and applying it to the current study, it is imperative to remember the concept of reciprocal causality.

Supporting systems theory of viewing an individual in their contextual whole is the idea that interactions within and between systems are circular and sequential, not linear.

This study suggests that there are barriers that occur within the macro-system of the individual's ecological environment. The macro-system represents the broad cultural and sub-cultural contexts. The Deaf community has its' own culture, language, and historical features. Higgins and Nash state in a structural functionalism manner:

That "hearing world" is not merely one in which people are assumed to be able to hear, but it is also one, which, to a great degree, is controlled by those who do hear. Deaf people living within a world which is not of their own making, but one which they must continually confront. In doing so, they live their lives." (1987, p. viii).

Therefore, a service provider's lack of cultural competency can be viewed as a barrier that stems from the macro-system level of the individual's environment, a predisposed broad system of a hearing world. This is relevant based on the concept that the overarching "patterns of ideology and organization of the social institutions common to a particular culture or subculture" are based on the majority hearing population (Bronfenbrenner, 1979, p.8).

Lack of resources are an apparent concern among efficient service delivery. With the advent of accessible technologies, many Deaf community members can communicate via text messaging systems, high speed Internet systems, and advanced text telephone messaging services including telephone



relay services. Despite the rapid development of such technology, many human service providers are limited by the socioeconomic priorities and regressive funding of social welfare systems. The additional benefits of technology subsidies added to human services system budgets could make text paging systems, video conferencing, current text telephone technology, closed captioning, real-time captioning, and secured computer network systems a reality ([Http://www.cms.hhs.gov/hipaa](http://www.cms.hhs.gov/hipaa)).

This study also suggests that there is an overlying stigma that is attached to mental illness as well as Deafness. Thus, discrimination, stereotypes and oppression are born out of the stigma held within the hearing macro-systemic context prohibiting fair and dignified access to Deaf individuals. Luey, Glass and Elliott (1995) describe the difference between the Deaf and hearing culture:

People who are not fluent in ASL, not culturally at home in the Deaf world, and not conversant with its political issues are likely to be perceived by the Deaf community as "hearies", regardless of their actual ability to hear. To Deaf people, the hearies represent a world that is at the very least different and, at worst, oppressive. (p.180)

As with stigma being attached to Deafness, additional barriers occur when the Deaf individual is of another race, ethnic background, religion or faith group, gender, sexual identity or, surprisingly, hearing status (internalized stigma in the Deaf community). Thus it is important to see that the larger cultural context affects a Deaf individual's access to mental health services. The barriers that are

present throughout the macro-system progressively reach the individual, a disenfranchised, potentially dual or multi-stigmatized micro-system.

The next systemic level where barriers occur is the exo-system. The exo-system is comprised of the larger social institutions and systems in which the individual does not directly interact with (Ashford et al., 1997). This study suggests that there are barriers that lie within this systemic level. These barriers are occurring due to insufficient Deaf Culture training for service providers. For example, law enforcement agencies do not get adequate training for dealing with the Deaf and Hard-of-Hearing population, especially regarding mental health crisis situations (S. Hegge & S. Hajjani, personal communication, May 21, 2003). Even though a particular individual may never be put in the situation where they must utilize law enforcement, they may still be affected by this potential part of the legal system.

If a Deaf individual who suffers from a mental illness witnesses or has knowledge of another situation involving culturally incompetent law enforcement, the individual may be less likely to seek assistance from law enforcement when really needed (i.e., suicidal ideation, rape, sexual assault). Another example could be training of sign language interpreters. Certainly, the quality of interpreting services is affected by the competency level of the interpreter's professional experience. Therefore, a Deaf individual who is seeking mental health services may get an interpreter that is not qualified for the specific job. Thus, the individual is affected again by an exo-systemic barrier to receiving mental health services.

The meso-system is comprised of the individual's personal systems such as "major groups, organizations, and institutions that touch the daily life of the individual such as school, work, church, recreations and community resources" (Turner, 1996, p. 608). The meso-system consists of the micro-systems that the individual interfaces; it is the micro-systems with the meso-system. According to the research, barriers that lie within this system are tantamount within the Community Service Agencies themselves. One barrier that occurs at this level is the accessibility to service providers who are themselves culturally Deaf. The study indicates that there is not an adequate amount of Deaf service providers working in the community. This research also shows that there are barriers that can occur regarding the inherent size or smallness of the Deaf community. The size of the Deaf community means that risk of confidentiality is perceived to be higher than in the hearing community. Barriers are also apparent when a Deaf individual attempts to access services through a hearing service provider who does not know the language. Thus, the service provider must utilize a skilled interpreter. This however, adds another person in the meeting between service provider and the Deaf individual seeking services. By adding another person, the dynamics change and the meeting automatically becomes less private and again, the issue of breaks in confidentiality arises.

The micro-system level "includes the individual's experience in his or her family, experiences at school, at work, in other social situations, or during leisure time, so that no other person experiences this environment in a similar way. The

micro environment is very important in the development of the individual and it determines the type of situations that an individual will encounter" (Turner, 1996).

This study showed that on the micro system level, there is a population of Deaf individuals that have additional needs. These additional needs affect the individual's micro-system in every way and the situation becomes more problematic when attempting to access services. This study also suggests that some individuals may have difficulty with communication, even in their native language, American Sign Language (ASL). Therefore, as the study suggests, these clients are seen as having behavioral issues. Having a chemical dependency problem also affects the individual at the micro-system level. This research indicates that clients who are in need of receiving mental health services, often times self medicate with drugs and alcohol. Thus, the chemical dependency issue creates another obstacle to obtaining mental health services for the deaf individual. The micro-system is the inner most core of the whole systemic structure that the individual is a part of. Viewing the system as a whole is a pertinent perspective and theory of social work practice.

#### Implications for Social Work Policy and Practice

Hepworth et al. (1997) state, "People often do not have access to adequate resources, or they lack effective coping methods. Social work involves assisting such people to find ways to meet their needs by linking them with or developing essential resources or by enhancing their capacities for utilizing resources or coping with environmental forces." (p. 18). Thus, in essence, social workers are the key to gaining access to certain parts of the systemic structure.

Pincus and Minahan (1973) state that the objective for social workers is "to help an individual or system obtain a needed resource or service or to obtain a policy change or concession from a resistant or unresponsive system" (p. 113). Deaf individuals who are in need of accessing mental health services and continue to encounter barriers often become frustrated and give up on getting their needs met. Social workers must delineate the sources of problems to be able to determine the focus of interventions when using the ecological systems model (Hepworth et al.).

Social work practice involves working with people from diverse cultures, backgrounds, experiences, and languages. Hepworth et al. (1997) quote the Council on Social Work Education as suggesting that, "social workers demonstrate respect for and acceptance of the unique characteristics of diverse populations" (p. 69). The National Association of Social Workers states in the Code of Ethics that social workers must "have a knowledge base of their clients' cultures and be able to demonstrate competence in the provision of services that are sensitive to clients' culture and to differences among people and cultural groups" ([Http://naswdc.org/pubs/code/code.asp](http://naswdc.org/pubs/code/code.asp)). Thus, a social worker is ethically and professionally responsible for having a knowledge base and being aware of Deaf culture. Hepworth et al. (1997) state that the task for practitioners "is to differentiate between behavior that is culturally mediated and that which is a product of individual personality. Possession of in-depth knowledge about a given cultural group facilitates making such differentiations, but when in doubt,

practitioners are advised to consult with well-informed and cooperative members of the ethnic group in question.” (p. 259).

Wu and Grant (1997) state:

Culture shapes ways of perceiving, perceptions themselves, and the interpretation of those perceptions. It sets up expectations about professional and client roles and responsibilities. Appropriate flexibility and responsiveness to cultural diversity on the part of a professional is key to building cultural bridges and will leave the client more open to ideas, resources, and practices that are culturally different and difficult for them (p. 87, 88).

Policymaking and program planning measures need to be implemented to ensure cultural competent decision making at the most strategic and political governing bodies. These include federal legislation, state lobbyists, supportive elected officials, community advocates and funding sources to construct feasible efforts to ensure broad civil and community integration for Deaf adults with mental illness. Consumer based organizations have a stake hold on providing advocacy services and membership participation toward advancing the policies and programs which serve Deaf adults with mental illness (National Association of the Mentally Ill, National Association of the Deaf, American Association of People with Disabilities, National Association of Social Workers). Clinical specialists in the field of Deafness and mental health, include clinical program advances promulgated by a specialized group of interdisciplinary professionals.

Standardized social work training and cultural competency with Deaf communities and regional networks are necessary to appropriately serve the population, delivering social justice and human dignity toward a linguistically disenfranchised subgroup. Social work training, glimpsing at disability communities, should include competency involving Deaf and Hard of Hearing persons with psychiatric disabilities, the individuals' experience in an audiological environment. Resources such as technology and medical advances are often discordant with cultural features of a historically established Deaf culture. Language and a discriminating medical community diminish the effectiveness of the services that are provided to this cultural minority group.

#### Limitations of the Study

Due to the small number of participants involved with this study, the results cannot be generalized to a wider population. Another limitation of this research is that participants were recruited by using a kind of purposeful sampling known as snowball or chain techniques (Patton, 1990). Therefore there is the likelihood of there being additional possible participants that were missed in the recruitment. This sampling only focused on gaining insight from one part of the population, which were the service providers themselves. This study did not attempt to gain information from the Deaf individuals who seek access to mental health services.

Another limitation of this study is that there was only one mailing of the questionnaire that was sent out. Only one mailing was sent out due to interests in time and budget limitations, but also the high return rate after the first mailing.

If a second mailing were to have been mailed out, there may have been more returned questionnaires, which would in turn lead to more data. Had this been a dissertation, the study could have been broadened to include possible recruits from rural Minnesota, or other states as well.

#### Generalizability

This sample taken from the service providers for Deaf and Hard of Hearing individuals within the Twin Cities Metro Area of Minnesota can only be representative of this population and therefore cannot be generalized to the larger population of Deaf individuals in all of Minnesota or across the United States. It also cannot be generalized due to the fact that this was not a randomly selected sample.

#### Suggestions for Future Research

Further research needs to be conducted to support and develop equally accessible mental health services to the Deaf and Hard of Hearing communities. One suggestion for an area of study is to research the perceptions of Deaf individuals who attempt to access the services. If research was undertaken with this population, the need for services would be portrayed in the light of the people who would be receiving the services. Also, the opinions and perspectives of Deaf individuals' family members is of importance if trying to strengthen the micro-systemic environment of the Deaf individual. Additionally, policies and program planning needs to be scrutinized to better understand the political aspects of inhibiting services to Deaf individuals in state, county, for profit and non-profit organizations. The economic atmosphere is implicit to the provision of



accessible services, and funding streams and budgeting play a pivotal role in making these services available to those that need them. This variable is an important feature to investigate. In summary, the gaps in services need to be outlined by collective interdisciplinary research.

## Chapter VII

### Conclusion

Perhaps the life of Jane Doe could have been saved. The findings of this research reflect the inconsistent and unjustified treatment of Jane Doe and her attempt to gain access to professional mental health services and emergency community care. Imagine a community that can serve a diversified population with unlimited access to human services and professionals ready and available to serve them. Social work practice attempts to make these changes possible.

The researcher is a mental health service provider who is invested in the emancipatory and codified ethical standards of the social work professional (Reamer, 1998). These ethics are grounded in professional values which serve to guide the conceptual standards across social work practice. The dignity and worth of a Deaf human being, social justice of Deaf community members, necessitate investigation and social change in the lives of those being served.

A Deaf person with a psychiatric disability in an environment constructed to serve a hearing world becomes disenfranchised; Social work practice serves to deconstruct the institutions and cultural norms associated with prohibiting equitable and culturally competent service provision. This think piece is an effort toward a more accessible future for Deaf persons with mental illness.

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• **INFORMATION AND CONSENT LETTER** •

**SYSTEMIC BARRIERS THAT PREVENT  
MENTAL HEALTH SERVICES FROM BEING  
ACCESSED BY THE DEAF POPULATION**

You are invited to be in a research study of systemic barriers that prevent mental health services from being accessed by the Deaf population. The researcher has selected you as a possible participant for one of two reasons. You or the agency you work for has been listed in the Professional and Consumer Resource Guide for Deaf and Hard of Hearing People that was compiled by the Minnesota Department of Human Services, Deaf and Hard of Hearing Services Division. The researcher has also identified possible participants by relying on her unique knowledge of the Deaf community and other service providers that have not been listed in the Professional and Consumer Resource Guide for Deaf and Hard of Hearing Services Division.

This study is being conducted by Jen Ruther-Uhrich, graduate student in the Department of Social Work at Augsburg College. This study is being conducted in partial fulfillment of the requirements for a master's degree in social work as part of my master's thesis.

**Background Information:**

The purpose of this study is to learn more about the barriers that keep mental health services from being accessed by the Deaf population. This study will explore systemic barriers that service providers for Deaf individuals identify.

**Procedures:**

If you agree to be a participant in this study, I would ask you to do the following:

- Read and then sign this Information and Consent Letter.
- Complete the questionnaire. The questionnaire will take approximately 15 to 20 minutes to complete. If there are any questions that you feel uncomfortable answering, please leave them blank.
- Return the signed Information and Consent Letter and the completed questionnaire in the self-addressed, stamped envelope by February 28, 2003.

**Risks and Benefits of Being in the Study:**

This study may have one risk. When an individual is asked to reply to questions regarding a culturally sensitive topic, it may bring up discomfort and or negative feelings. That is why you are not required to answer questions in which you would feel uncomfortable doing so.

There are no direct benefits or compensation for participating in this study. The indirect benefits of participating in this study will be to identify systemic barriers that the Deaf population faces when trying to access mental health services. Other indirect benefits to participation are contribution of knowledge to the field, and future policy and program planning. Upon your request, a summary of the study will be made available to you to assist your organization in future planning.

In the event this research activity results in the need for debriefing or counseling services, you will be given the phone numbers for Regions Hospital Health and Wellness Center for Deaf and Hard of Hearing and the Communication Services for the Deaf. However, payment for any of these services must be made by you or your health insurance provider.

**Confidentiality:**

The identities of the participants will be kept anonymous and confidential to the thesis advisor. Research records will be kept in a locked file; only the researcher will have access to the records. Raw data will be destroyed August 31, 2003.

**Voluntary Nature of the Study:**

Your decision whether or not to participate will not affect your current or future relations with Augsburg College or the private investigator. If you decide to participate, you are free to withdraw at any time without affecting those relationships.

**Contacts and Questions:**

The researcher conducting the study is Jen Ruther-Uhrich. You may ask any questions you have now or later. You may contact her at (612) 408-4003 (Voice) or by e-mail at [JenRutherUhrich@aol.com](mailto:JenRutherUhrich@aol.com).

Ms. Ruther-Uhrich's thesis advisor is Laura Boisen, PhD, Department of Social Work, Augsburg College. She is also available for questions and can be contacted at (612) 330-1439.

**Statement of Consent:**

I have read the above information. I have asked questions and have received answers. I consent to participate in this study.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Signature of investigator \_\_\_\_\_ Date \_\_\_\_\_

I consent to allow use of my direct quotations in the written manuscript or presentations. These direct quotations will be anonymous.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Thank You!

Your assistance and participation is greatly appreciated.

Jen Ruther-Uhrich

(Institutional Review Board • Augsburg College • Approval Number • 2003-6-2)

• **QUESTIONNAIRE** •

**SYSTEMIC BARRIERS THAT PREVENT MENTAL HEALTH SERVICES  
FROM BEING ACCESSED BY THE DEAF POPULATION**

Thank you for taking the time to complete this questionnaire. Please do not write your name on this survey. All individual responses will be kept confidential. There are no right or wrong answers. Please place a checkmark next to your answer. If you have additional comments, please feel free to use the space provided and attach a separate piece of paper if necessary. Lastly, you are not required to answer questions that you are uncomfortable answering. Please return the questionnaire and consent form by February 28, 2003.

**Section A:** The questions in this section are designed to get an idea of the agencies and organizations that currently serve adults who are Deaf and in need of mental health services within the Twin Cities metro area. It is also designed to gather general information about the population of Deaf individuals that receive services from your organization.

1. What is the function of your organization as it relates to providing services to individuals who identify themselves as Deaf? (check all that apply)

Advocacy / Information / Referral  
 Chemical Dependency Treatment  
 Education  
 Employment / Rehabilitation Services  
 Independent Living Services  
 Interpreting Services  
 Medical  
 Mental Health  
 Religious  
 Social Services  
 Other: \_\_\_\_\_

2. Per year, how many Deaf individuals does your organization serve?

0-10  
 11-20  
 21-30  
 31-40  
 41-50  
 Over 50

3. What is the age range of the Deaf individuals that your organization serves? (check all that apply)

under age 18  
 18 to 30  
 31 to 40  
 41 to 50  
 51 to 60  
 61 to 70  
 over age 70

4. If any, what is the percentage of Deaf individuals who are served by your organization that have a diagnosis of a mental disorder as described in the Diagnostic and Statistical Manual of Mental Disorders Fourth Edition (DSM IV)?

- 0-20 %
- 21-40 %
- 41-60 %
- 61-80 %
- 81-100%

5. What are the racial/ethnic groups of the Deaf individuals that you serve? (check all that apply)

- African American
- American Indian / Alaskan Native
- Asian / Pacific Islander
- Caucasian
- Hispanic / Latino
- Other: \_\_\_\_\_

6. How do you identify yourself? (check all that apply)

- Deaf
- Hard of Hearing
- Hearing
- Other: \_\_\_\_\_

7. What is your current job title? \_\_\_\_\_

**Section B:** This section of the survey is designed to gain information about the context and environment that a Deaf individual lives within. The researcher is interested in how a Deaf individual's direct and indirect environment has an impact on their accessibility to mental health services.

8. Do mental health service professionals need cultural specific training to provide adequate mental health services to the Deaf community? \*(Examples of mental health service professionals are; psychiatrists, psychologists, psychiatric nurses, therapists, counselors, social workers)

- Yes
- No

Please explain your answer: \_\_\_\_\_  
\_\_\_\_\_

9. Do Deaf individuals who are of a racial/ethnic group other than Caucasian face extra challenges when trying to access mental health services?

- Yes
- No

Please explain your answer: \_\_\_\_\_  
\_\_\_\_\_

10. Is there a stigma attached to mental illness in the Deaf community?

- Yes
- No

Please explain your answer: \_\_\_\_\_

11. Are there enough sign language interpreters that are adequately trained to interpret in the area of mental health services?

Yes  
 No

Please explain your answer: \_\_\_\_\_

12. Are law enforcement agencies (i.e. police) adequately equipped and trained to work with a person who is Deaf and in need of crisis intervention?

Yes  
 No

Please explain your answer: \_\_\_\_\_

13. It is more effective for an individual who is Deaf to receive mental health services from a professional who is also Deaf rather than a hearing professional who knows sign language?

Yes  
 No

Please explain your answer: \_\_\_\_\_

14. Do individuals who are Deaf have an opportunity to take an active part in planning their mental health care and treatment (i.e. diagnosis, therapy, medication)?

Yes  
 No

Please explain your answer: \_\_\_\_\_

15. Are there opportunities for families to participate in the mental health care and treatment of a family member who is Deaf? *(check only one)*

Yes  
 No

Please explain your answer: \_\_\_\_\_

16. Does having a chemical abuse / chemical dependency problem (as listed in the DSM IV) affect a Deaf individual's access to mental health services?

Yes  
 No

Please explain your answer: \_\_\_\_\_

Comments regarding the study or additional information you would like to provide:

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Thank you for your assistance in completing this questionnaire.

If you have any questions, please contact me at (612) 408-4003 Voice or e-mail at [JenRutherUhrich@aol.com](mailto:JenRutherUhrich@aol.com).

Please return the completed questionnaire and consent form  
in the self-addressed stamped envelope provided by

**FEBRUARY 28, 2003**

**Thank you!**

**Jen L. Ruther-Uhrich**

Please send me a summary of the study!

Name	_____
Title	_____
Organization	_____
Address	_____
	_____
Telephone	_____

Institutional Research Board  
Augsburg College  
Box 107

January 30, 2003

To: Jennifer Ruther-Uhrich

From: Norma C. Noonan, Chair



I am pleased to inform you that the IRB has approved your application the project: Systemic Barriers that Prevent Mental Health Services from Being Accessed by the Deaf Population

as submitted

as revised

with the following conditions:

Your IRB approval number which should be noted in your written project and in any major documents alluding to the research project is as follows:

**2003-6-2**

I wish you success with your project. If you have any questions, you may contact me: 612-330-1198 or [noonan@augsborg.edu](mailto:noonan@augsborg.edu).

The readers have a few suggestions that I can share with you.

c. Laura Boisen



Lynn... 10

Jen Ruther-Uhrich  
5230 Balsam Lane North  
Plymouth, MN 55442  
(763) 550-9316 v/tty - (612) 408-4003

February 11, 2003

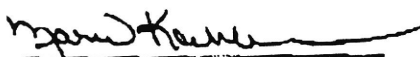
Marie Koehler  
Manager  
Minnesota Department of Human Services  
Deaf and Hard of Hearing division, Metro Region  
444 Lafayette Road  
St. Paul, MN 55155-3184

Dear Ms. Koehler,

This is a letter to follow up with our phone message conversations regarding my thesis project titled "Systemic Barriers That Prevent Mental Health Services from Being Accessed by the Deaf Population." As we have discussed, I am requesting permission to utilize the most recently published Professional and Consumer Resource Guide for People Who are Deaf and Hard of Hearing that was compiled by the Minnesota Department of Human Services, Metro Region. It would be mentioned in the study's Information and Consent Letter that the invited participant or the agency that they work for may have been listed in the guide. The guide will also be listed in References section of the finalized project. I understand and agree that names and or addresses will not be duplicated or released to another organization or person for any other purpose.

You have verbally stated that approval and permission has already been granted to use the guide for my thesis project. Please sign the consent form below to confirm approval. I appreciate the time you have committed to my project. Please feel free to call me if you have any questions or concerns. I can be reached at (763) 550-9316 v/tty, or (612) 408-4003 voice.

Jen Ruther-Uhrich has permission and approval to use the most recently published Professional and Consumer Resource Guide for People Who are Deaf and Hard of Hearing to find possible participants for this study. This study is in partial fulfillment of her Masters of Social Work from Augsburg College. The Resource Guide will be used as a resource to locate various service providers for Deaf and Hard of Hearing individuals. These service providers will be considered potential participants in the study. The researcher understands and agrees that names and or addresses will not be duplicated or released to another organization or person for any other purpose.


  
Marie Koehler

6-5-03  
Date

  
Jen Ruther-Uhrich

10-5-03  
Date

Thank you,

  
Jen Ruther-Uhrich

Augsburg College  
Lindell Library  
Minneapolis, MN 55454